House of Representatives

General Assembly

File No. 298

February Session, 2014

Substitute House Bill No. 5345

House of Representatives, April 2, 2014

The Committee on Labor and Public Employees reported through REP. TERCYAK of the 26th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING COOPERATIVE HEALTH CARE ARRANGEMENTS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective October 1, 2014*) As used in this section and sections 2 to 11, inclusive:

(1) "Health care collaborative" means an entity comprised of health care practitioners who practice in two or more separate firms and that has (A) entered or plans to enter into a compensation agreement with a health plan to incentivize quality over volume and place healthcare practitioners at risk for some or all of the costs of inefficient health care delivery, or (B) arranged to implement an ongoing program to evaluate and modify health care practitioner practice patterns and create interdependence and cooperation among health care practitioners for the purpose of efficiently delivering health care;

(2) "Prospective health care collaborative" means an entity

comprised of health care practitioners who practice in two or more separate firms that (A) is seeking recognition as a health care collaborative, or (B) has been issued a preliminary certificate of public advantage by the Office of the Healthcare Advocate;

(3) "Health care practitioner" means (A) a physician licensed under chapter 370 of the general statutes, (B) a chiropractor licensed under chapter 372 of the general statutes, (C) a podiatrist licensed under chapter 375 of the general statutes, (D) a naturopath licensed under chapter 373 of the general statutes, or (E) an optometrist licensed under chapter 380 of the general statutes;

(4) "Health plan" means an entity that pays for health care services, including, but not limited to, commercial health insurance plans, self-insurance plans, health maintenance organizations, managed care organizations, as defined in section 38a-478 of the general statutes, or any insurer or corporation subject to the insurance laws of this state;

(5) "Preliminary certificate of public advantage" means the written authorization issued by the Office of the Healthcare Advocate authorizing a prospective health care collaborative to enter into negotiations with a health plan regarding compensation, prices and certain terms and conditions of service;

(6) "Certificate of public advantage" means the certificate issued by the Office of the Healthcare Advocate authorizing a health care collaborative to implement a final agreement with a health plan on compensation, prices and certain terms and conditions of service, subject to the supervision of the Healthcare Advocate; and

(7) "Person" means an individual, association, corporation or any other legal entity.

Sec. 2. (NEW) (*Effective October 1, 2014*) (a) Notwithstanding chapter 624 of the general statutes, a prospective health care collaborative or a health care collaborative may negotiate on behalf of itself and its associated health care practitioners and enter into agreements with

health plans to provide health care items and services for which benefits are provided under such health plans, provided the Healthcare Advocate determines that the prospective health care collaborative or health care collaborative complies with the requirements of sections 1 to 11, inclusive, of this act.

(b) Nothing in sections 1 to 11, inclusive, of this act shall be deemed to limit the right of health care practitioners collectively to negotiate and jointly to contract with health plans without complying with the requirements of sections 1 to 11, inclusive, of this act.

(c) Nothing in sections 1 to 11, inclusive, of this act shall be deemed to affect or limit a health care practitioner from exercising his or her rights under the National Labor Relations Act, 49 Stat. 449 (1935), 29 USC 151 et seq., or any other applicable provisions of federal or state law.

Sec. 3. (NEW) (*Effective October 1, 2014*) (a) Prior to negotiating and contracting with a health plan, a prospective health care collaborative shall:

(1) Apply for and obtain a preliminary certificate of public advantage from the Office of the Healthcare Advocate. Such application shall be in a form prescribed by the Healthcare Advocate and shall identify: (A) The name of the prospective health care collaborative, (B) the names of the health care practitioners associated with the prospective health care collaborative, (C) (i) the manner in which the prospective health care collaborative's proposed method of health plan payment incentivizes quality over volume and places health care practitioners at risk for some or all of any inefficient health care delivery, or (ii) the prospective health care collaborative's arrangements to implement an active and ongoing program to evaluate and modify health care practitioner practice patterns and create interdependence and cooperation among health care practitioners for the purpose of efficiently delivering care, (D) the name of the health plan, (E) the expected effects of the negotiated contract on the quality and price of health care practitioner services,

and (F) any other information as the Healthcare Advocate may prescribe; and

(2) Be found to be a health care collaborative by the Healthcare Advocate.

(b) No prospective health care collaborative shall engage in negotiations for the purpose of contracting with a health plan without first being granted a preliminary certificate of public advantage by the Healthcare Advocate.

(c) The Healthcare Advocate shall find that a prospective health care collaborative is a health care collaborative if such prospective health care collaborative (1) has placed or plans to place its associated health care practitioners at risk for some or all of their inefficient health care delivery through methods, including, but not limited to, pay-for-performance, capitation, shared savings and costs, bundled payment arrangements or other financial incentives or risk assumption mechanisms based in whole or in part on per episode, per population or per procedure costs, outcomes, patient satisfaction, education or welfare activities; or (2) implements an active and ongoing program to modify practice patterns by the health care collaborative's health care practitioners and creates a high degree of interdependence and cooperation among the health care practitioners to insure quality, including: (A) Mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; (B) selecting network health compensations that are likely to further these efficiency objectives; or (C) investing capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.

(d) Not later than twenty days after receiving a prospective health care collaborative's application, the Healthcare Advocate shall notify, in writing, such prospective health care collaborative of his or her decision to approve or reject such application. If the Healthcare Advocate rejects such application, he or she shall furnish a written explanation of any deficiencies, along with a statement of specific

proposals for remedial measures to cure such deficiencies. The Healthcare Advocate may conduct a hearing, after giving notice to all interested parties, to obtain information necessary to make such decision.

Sec. 4. (NEW) (*Effective October 1, 2014*) (a) Upon receipt of a preliminary certificate of public advantage from the Healthcare Advocate authorizing negotiations between a health care collaborative and a health plan, a health care collaborative shall notify the Healthcare Advocate of any of the following events not later than fourteen days after the occurrence of such event: (1) The commencement of negotiations; (2) the conclusion of negotiations; (3) an impasse in the negotiations; or (4) the health plan's refusal to negotiate, cancellation of negotiations or failure to respond to a negotiation request. In such instances, a health care collaborative may request intervention from the Healthcare Advocate to require the health plan to participate in the negotiation pursuant to subsection (b) of this section.

(b) If the Healthcare Advocate determines that an impasse exists in the negotiations, or in the event a health plan declines to negotiate, cancels negotiations or fails to respond to a request for negotiation, the Healthcare Advocate shall:

(1) Designate a mediator to assist the parties in commencing or continuing such negotiations and in reaching a settlement of the issues presented in such negotiations. The mediator designated shall be experienced in health care mediation and shall be drawn from a list of such mediators maintained by the Healthcare Advocate, the American Arbitration Association or the Federal Mediation and Conciliation Service. The mediator so designated may only serve if approved by both parties. If the mediator is successful in resolving the impasse, the health care collaborative shall proceed as set forth in section 5 of this act; and

(2) If, after a reasonable period of mediation, the parties are unable to reach an agreement, appoint a fact-finding board of not more than

three members drawn from the list of mediators maintained by the Healthcare Advocate, the American Arbitration Association or the Federal Mediation and Conciliation Service. Upon a vote of the majority of its members, the board shall have the power to make recommendations for the resolution of the dispute.

(c) The fact-finding board shall, not later than sixty days after the board's appointment, submit, in writing, its findings and recommendations to the Healthcare Advocate, the health care collaborative and the health plan. If the impasse continues beyond twenty days from the date on which the board submitted its findings and recommendations, the Healthcare Advocate shall order a resolution to the negotiations based upon the findings of fact and recommendations submitted by the board.

(d) (1) A health plan shall be prohibited from refusing to negotiate in good faith with a health care collaborative. Whenever, in the judgment of the Healthcare Advocate, a health plan has refused to negotiate in good faith with a health care collaborative in violation of this subsection, or any regulation adopted or order issued pursuant to this section, at the request of the Healthcare Advocate, the Attorney General may bring an action in the superior court for the judicial district of New Britain for an order directing compliance with this subsection. The Healthcare Advocate shall have the discretion to observe such good faith negotiations between the health plan and the health care collaborative.

(2) Any health plan that violates the provisions of this subsection shall be subject to a civil penalty of not more than twenty-five thousand dollars, to be fixed by the court, for each day for each violation. Each violation shall be a separate and distinct offense and, in the case of a continuing violation, each day's continuance thereof shall be deemed to be a separate and distinct offense. Upon request of the Healthcare Advocate, the Attorney General shall institute a civil action in the superior court for the judicial district of New Britain to recover such penalty.

Sec. 5. (NEW) (*Effective October 1, 2014*) (a) Any agreement negotiated pursuant to sections 1 to 11, inclusive, of this act between a health care collaborative and a health plan shall be submitted to the Healthcare Advocate for an examination of its terms to determine whether such agreement shall be approved or rejected, in accordance with subsection (b) of this section.

(b) Not later than sixty days after submission of the agreement, the Healthcare Advocate shall provide a tentative decision to approve or reject the agreement. The Healthcare Advocate shall provide such decision after issuing public notice and providing a thirty-day opportunity for public comment regarding such opinion. The Healthcare Advocate's tentative decision shall be accompanied by a written opinion expressly considering the agreement's expected effects on the reasonableness of fees and the quality and price of health care practitioner services. No agreement shall become final and effective unless and until, following the thirty-day comment period, the Healthcare Advocate approves the agreement and issues a certificate of public advantage on the basis that the agreement fosters reasonably priced, quality practitioner services. The Healthcare Advocate may collect information from any person to assist in evaluating the impact of the proposed agreement on the health care marketplace.

(c) In determining the reasonableness of fees and quality of services, the Healthcare Advocate shall consider whether the health care collaborative's proposed fees:

(1) Are consistent with fees in similar practitioner communities;

(2) Ensure reasonable access to practitioner care;

(3) Improve the health care collaborative's ability to render services efficiently;

(4) Provide for the financial stability of the health care collaborative; and

(5) Encourage innovative approaches to medical care that may

improve patient outcomes and lower health care costs.

Sec. 6. (NEW) (*Effective October 1, 2014*) The Healthcare Advocate shall actively monitor agreements approved under sections 1 to 11, inclusive, of this act to ensure that a health care collaborative's performance under the agreement remains in compliance with the conditions of approval. Upon request and at least annually, each health plan and health care collaborative operating under a certificate of public advantage shall submit to the Healthcare Advocate a written report, in the form and manner prescribed by the Healthcare Advocate, regarding agreement compliance. The Healthcare Advocate may revoke a certificate of public advantage upon a finding that performance pursuant to the agreement is not in substantial compliance with the terms of the application or the conditions of approval and issuance of a certificate of public advantage.

Sec. 7. (NEW) (*Effective October 1, 2014*) Any person aggrieved by a final decision of the Healthcare Advocate under sections 1 to 11, inclusive, of this act may appeal the decision to the Superior Court in accordance with section 4-183 of the general statutes.

Sec. 8. (NEW) (*Effective October 1, 2014*) Any applications, reports, records, documents or other information obtained by the Healthcare Advocate pursuant to sections 1 to 11, inclusive, of this act shall not be subject to disclosure under the Freedom of Information Act, as defined in section 1-200 of the general statutes.

Sec. 9. (NEW) (*Effective October 1, 2014*) (a) The Healthcare Advocate shall charge each prospective health care collaborative an administrative fee of one thousand dollars for determining whether such prospective health care collaborative is authorized to engage in negotiations with a health plan within the authority granted under sections 1 to 11, inclusive, of this act.

(b) The Healthcare Advocate shall set fees in amounts deemed reasonable and necessary for determining whether the agreement between the prospective health care collaborative and a health plan

shall be approved or disapproved.

Sec. 10. (NEW) (*Effective October 1, 2014*) On or before October 1, 2015, and annually thereafter, the Healthcare Advocate shall submit, in accordance with the provisions of section 11-4a of the general statutes, to the Governor and the joint standing committee of the General Assembly having cognizance of matters relating to labor and public employees an annual report on the operations and activities of the Healthcare Advocate pursuant to sections 1 to 11, inclusive, of this act.

Sec. 11. (NEW) (*Effective October 1, 2014*) If any provision of this section and sections 1 to 10, inclusive, of this act, or its application to any person or circumstance, is held invalid by a court of competent jurisdiction, the invalidity shall not affect any other provisions or applications of this section and sections 1 to 10, inclusive, of this act, that can be given effect without the invalid provision or application, and to this end such provisions are severable. The provisions of this section and sections 1 to 10, inclusive, of this act shall be liberally construed to effect the purposes thereof.

Sec. 12. (NEW) (*Effective October 1, 2014*) The Healthcare Advocate shall adopt rules and regulations, pursuant to chapter 54 of the general statutes, establishing application and review procedures, methods for determining whether to issue a certificate of public advantage and any other procedures or standards necessary for the administration of sections 1 to 11, inclusive, of this act.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2014*	New section
Sec. 2	*October 1, 2014*	New section
Sec. 3	*October 1, 2014*	New section
Sec. 4	*October 1, 2014*	New section
Sec. 5	*October 1, 2014*	New section
Sec. 6	*October 1, 2014*	New section
Sec. 7	*October 1, 2014*	New section
Sec. 8	*October 1, 2014*	New section

Sec. 9	*October 1, 2014*	New section
Sec. 10	*October 1, 2014*	New section
Sec. 11	*October 1, 2014*	New section
Sec. 12	*October 1, 2014*	New section

Statement of Legislative Commissioners:
In section 3(a)(1), clauses (i) and (ii) were inserted in subparagraph (C), "(D)" was deleted, and subparagraphs (E) to (G), inclusive, were redesignated as subparagraphs (D) to (F), inclusive, for clarity and internal consistency.

LAB *Joint Favorable Subst. -LCO*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 15 $	FY 16 $
Healthcare Advocate, Off.	IF - Cost	721,803	740,457
Attorney General	GF - Potential Cost	Zero to 10,000	Zero to 10,000
Resources of the General Fund	GF - Revenue Gain	Indeterminate	Indeterminate

Municipal Impact: None

Explanation

The bill is anticipated to result in a cost of $721,803 to the Insurance Fund (IF) in FY 15 for four attorneys, one paralegal and one health care analyst in the Office of the Healthcare Advocate (OHA) to certify and oversee authorized cooperative health care arrangements. This cost includes $455,000 in Personal Services, $25,000 in Other Expenses, $75,000 in consultant fees and $166,803 to provide fringe benefits. These employees will be necessary to review these arrangements and issue written decisions approving or denying applications for certificates of public advantage, which authorize health care providers to engage in conduct that could lessen health care competition. Hearings may be necessary to obtain background information. In addition, the OHA must actively supervise authorized cooperative health care arrangements and review annual reports submitted by parties to authorized cooperative health care arrangements. It is anticipated that in excess of ten cooperative arrangements may occur.

The bill results in a potential revenue gain of less than $50,000 as it requires managed care companies to negotiate in good faith with health care providers holding a certificate of public advantage issued

by the OHA. A company that fails to do so faces a daily $25,000 civil fine.

Additionally, the bill requires the OHA to charge each prospective health care collaborative an administrative fee of $1,000 to determine whether such cooperative is authorized to negotiate. The OHA is also required to set fees in amounts necessary to determine whether an agreement between a collaborative and a health plan shell be approved or disapproved. As it is at the discretion of the OHA to set the amount of these fees, it is uncertain what revenue will be generated.

Additionally, the potential fiscal impact to the Office of the Attorney General is a cost of zero to $10,000 annually beginning in FY 15 for potential litigation costs related to: (1) obtaining court orders directing health care plan compliance and (2) the recovery of penalties established under the bill.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis

HB 5345

AN ACT CONCERNING COOPERATIVE HEALTH CARE ARRANGEMENTS.

SUMMARY:

This bill permits health care practitioners from two or more firms to form a health care collaborative ("collaborative") to negotiate as a group with insurers, managed care organizations (MCO), or other similar groups for compensation, prices, and conditions of service. It defines practitioners as licensed (1) physicians, (2) chiropractors, (3) podiatrists, (4) naturopaths, and (5) optometrists. A collaborative must apply to the Office of Healthcare Advocate (OHA) for approval to (1) negotiate an agreement and (2) implement any final agreement.

The bill exempts collaboratives from state antitrust law if they operate under the bill's provisions (see BACKGROUND). It is not clear whether, despite being exempted from state antitrust law, collaboratives would be considered a violation of federal antitrust law.

Under the bill, when negotiations stall between a collaborative and an insurer or MCO, the healthcare advocate must take steps to help the parties reach an agreement. If there is an impasse, the advocate must order a resolution, which is presumably binding on both parties. An insurer or MCO can face civil penalties for refusing to negotiate with a collaborative.

The bill authorizes OHA to issue certificates of public advantage (CPAs) that permit collaboratives to negotiate. It requires OHA to regulate collaboratives and gives it authority to revoke their certificates for failing to comply with their application or terms of approval.

The bill exempts all applications, reports, records, documents, and

other information obtained by the advocate due to activities under the bill from the Freedom of Information Act.

The bill also includes provisions addressing (1) appealing the advocate's decisions to Superior Court, (2) charging prospective collaboratives an administrative fee, (3) requiring the advocate to report annually to the governor and General Assembly, and (4) adopting regulations.

EFFECTIVE DATE: October 1, 2014

§ 2 — HEALTH CARE COLLABORATIVE AUTHORITY TO NEGOTIATE

The bill permits a prospective collaborative or a collaborative to negotiate on behalf of itself and its practitioners and enter into agreements with health plans to provide health care items and services under the plans, provided the healthcare advocate determines the prospective collaborative or collaborative complies with the bill's requirements (see "Certificate Process" below regarding authority to negotiate).

It defines "prospective health care collaborative" as an entity comprised of health care practitioners who practice in two or more separate firms that (1) is seeking recognition as a health care collaborative, or (2) has received preliminary CPA from OHA. A "health care collaborative" is an entity comprised of practitioners who practice in two or more separate firms and that has:

1. entered or plans to enter into a compensation agreement with a health plan to incentivize quality over volume and place practitioners at risk for some or all of the costs of inefficient care delivery, or

2. arranged to implement an ongoing program to evaluate and modify practitioner practice patterns and create interdependence and cooperation among practitioners to ensure efficient delivery of care.

The bill does not define phrases such as "incentivize quality over volume" and "place practitioners at risk for some of all of the costs of inefficient care delivery." Presumably, they refer to methods to financially reward efficient care delivery.

It defines a "health plan" as an entity that pays for health care services, including commercial health insurance plans, self-insurance plans, health maintenance organizations (HMOs), MCOs, or any insurer or corporation under state insurance law. It is not clear whether the bill's provisions could apply to self-insured plans because a federal law, the Employee Retirement Income Security Act (ERISA), exempts self-insured plans from state regulations (see BACKGROUND).

The bill specifies that it does not limit a practitioner from exercising his or her rights under the National Labor Relations Act (29 USC 151 et seq.) or any other applicable federal or state law.

§ 3 — CERTIFICATE PROCESS

Preliminary Certificates of Public Advantage (CPA)

Before any negotiations take place, OHA must (1) grant the collaborative a preliminary CPA and (2) determine it is a health care collaborative. The collaborative must apply to OHA for a preliminary certificate.

The bill requires the application to include:

1. the prospective collaborative's name,
2. the names of the practitioners included,
3. the health plan's name,
4. the expected effects of the contract on the quality and price of practitioner services,
5. either the collaborative's (a) proposed method of health plan payment designed to incentivize quality over volume and place

practitioners at risk for some or all of any inefficient health care delivery or (b) arrangements to evaluate and modify practitioner practice and create practitioner interdependence and cooperation in order to efficiently deliver care, and

6. any other information the advocate requests.

Criteria and Decision on Applications

The bill requires that, for OHA to find that a prospective collaborative is a collaborative (i.e., no longer just "prospective"), it must meet one of two criteria intended to control costs while maintaining patient care.

A collaborative must either:

1. place or plan to place its practitioners at risk for some or all of their inefficient health-care delivery through methods, including pay-for-performance, capitation, shared savings and costs, bundled payment arrangements, or other financial incentives or risk assumption mechanisms based in whole or in part on per-episode, per-population, or per-procedure costs, outcomes, patient satisfaction, education, or welfare activities; or

2. implement a program to modify practitioner practice patterns and create interdependence and cooperation among the practitioners to ensure quality. The latter includes (a) cost control and quality-of-care mechanisms to monitor and control utilization of health care services, (b) selecting network health compensations intended to further the efficiency aims, or (c) investing monetary and human capital in the necessary infrastructure and capability to achieve the efficiencies.

The bill does not define these terms or concepts. It also does not detail how OHA is to evaluate these cost-control mechanisms or programs to create cooperation and monitor utilization or promote efficiency.

The bill requires OHA to decide on a prospective collaborative's application within 20 days of receiving it. OHA must notify the collaborative in writing of the decision to approve or reject. If it rejects an application, OHA must furnish a written explanation of any deficiencies, along with specific proposals for remedial measures to address them.

The bill gives OHA the option of conducting a hearing, after giving notice to the parties, to obtain information necessary to decide on the application.

§4 — NEGOTIATIONS

Notification to OHA

Under the bill, once the collaborative receives a preliminary certificate, it must notify OHA no later than 14 days after any of the following events occur:

1. negotiations begin;
2. negotiations conclude;
3. negotiations reach an impasse; or
4. a health plan's refusal to negotiate, cancellation of negotiations, or failure to respond to a negotiation request.

Impasse or Failure to Negotiate

Under the bill, several situations require OHA to act. If (1) the advocate determines that negotiations are at an impasse or (2) a health plan declines to negotiate, cancels negotiations, or fails to respond to a request for negotiation, the advocate must designate a mediator to assist the parties in starting or continuing negotiations and in reaching a settlement of the issues presented in negotiation.

The mediator designated must be experienced in health care mediation and selected from a list of mediators maintained by the advocate, the American Arbitration Association, or the Federal Mediation and Conciliation Service. Both parties must agree on the

mediator.

If, after a reasonable period of mediation (not defined), the parties are unable to agree, the advocate must appoint a fact-finding board of not more than three members drawn from the list of mediators she maintains, the American Arbitration Association, or the Federal Mediation and Conciliation Service. A majority of board's members may vote to make recommendations for the resolution of the negotiations.

Advocate Order to End Impasse

The fact-finding board must also, no later than 60 days after the members are appointed, submit its findings and recommendations in writing to the advocate, the collaborative, and the health plan. If the impasse continues longer than 20 days after the date of submission, the advocate must order a resolution to the negotiations based on the board's findings of fact and recommendations. (It appears that the resolution is binding on both parties, but the bill does not specify this.)

Refusal to Negotiate and Penalty

The bill prohibits a health plan from refusing to negotiate in good faith with a collaborative. Whenever, in the advocate's judgment, a plan has refused to negotiate in good faith in violation of the bill or any regulation adopted or order issued related to the bill, the advocate can ask the attorney general to bring an action in the New Britain Superior Court for an order directing the plan to comply.

The advocate has the discretion to observe the good faith negotiations between the plan and the collaborative.

A plan that refuses to negotiate is subject to a civil penalty of up to $25,000, to be fixed by the court, for each day of each violation. The bill requires each violation be a separate and distinct offense and, in the case of a continuing violation, each day's continuance is considered a separate and distinct offense. At the advocate's request, the attorney general must institute a civil action in the New Britain Superior Court to recover the penalty.

§5 — REVIEW OF AGREEMENTS AND CERTIFICATE OF PUBLIC ADVANTAGE

All agreements negotiated under the bill must be submitted to the advocate for review and either approved or rejected.

Within 60 days after receiving an agreement, the advocate must provide a tentative approval or rejection. Before issuing a decision, the advocate must issue a public notice and allow a 30-day public comment period regarding the opinion. The advocate's tentative decision must be accompanied by a written opinion on the agreement's expected effects on the reasonableness of fees and the quality and price of services. It is not clear whether the tentative decision and opinion are to be issued (1) in time to be commented on during the 30-day comment period or (2) after the comment period.

No agreement can become final and effective unless and until, following the comment period, the advocate approves the agreement and issues a CPA on the basis that the agreement fosters reasonably priced, quality practitioner services. The bill permits the advocate to collect information from any person to assist in evaluating the impact of the proposed agreement on the health care marketplace.

In determining the reasonableness of service fees and quality, the advocate must consider whether the collaborative's proposed fees:

1. are consistent with fees in similar practitioner communities,
2. ensure reasonable access to care,
3. improve the collaborative's ability to provide services efficiently,
4. provide for the collaborative's financial stability, and
5. encourage innovative approaches to medical care that could improve patient outcomes and lower costs.

§6 — CERTIFICATE REVOCATION

The advocate must actively monitor agreements approved under

the bill to ensure that a health care collaborative's performance remains in compliance with the approval conditions. Upon request and at least annually, each health plan and collaborative operating under a CPA must submit a written report regarding agreement compliance to the advocate, who can prescribe the report's form.

The advocate can revoke a CPA upon a finding that performance under the agreement is not in substantial compliance with the terms of the application or the conditions of CPA approval.

§7 — APPEAL OF ADVOCATE'S DECISIONS

Under the bill, any person aggrieved by the advocate's final decision can appeal the decision to Superior Court according to state law. The bill defines "person" as an individual, association, corporation, or any other legal entity.

§9 — ADMINISTRATIVE FEE

The advocate must charge each prospective collaborative a $1,000 administrative fee for determining whether the collaborative can engage in negotiations with a health plan within the bill's parameters. The advocate must set fees in amounts deemed reasonable and necessary for determining whether the agreement between the prospective collaborative and a health plan will be approved or disapproved. The language requiring a $1,000 fee appears to conflict with the language that gives the advocate some leeway to set fees that are "deemed reasonable and necessary" which may not be $1,000.

§10 — ANNUAL REPORT TO GENERAL ASSEMBLY AND GOVERNOR

By October 1, 2015, and every following year, the advocate must submit an annual report on the advocate's operations and activities under the bill to the governor and the Labor and Public Employees Committee.

§ 12 — REGULATIONS

The advocate must adopt rules and regulations establishing application and review procedures, methods for determining whether

to issue a CPA, and any other procedures or standards needed to administer the bill's provisions.

BACKGROUND

Related Bill

sSB 35, favorably reported by the Public Health Committee, requires health care providers and hospitals to notify the attorney general when provider practices of eight or more physicians are purchased or merged.

Antitrust Law

With limited exceptions, state and federal law prohibit restraint of any part of trade or commerce, including contracts intended to, or that have the effect of:

1. price fixing;

2. fixing, controlling, maintaining, limiting, or discontinuing the production, manufacture, mining, sale, or supply of any part of trade or commerce;

3. allocating or dividing customers or markets, either functionally or geographically, in any part of trade or commerce; or

4. refusing to deal or coercing, persuading, or inducing third parties to refuse to deal with another person.

The attorney general is authorized to litigate state and federal antitrust cases. Persons, including consumers, are also entitled to file suit and may recover treble damages for the injury to their business or property, plus reasonable attorney's fees.

ERISA

Generally, a state insurance law does not apply to a company's self-insured benefit plan because the federal ERISA preempts state law for self-insured plans (29 USC Chapter 18).

ERISA prohibits states from "deeming" self-funded plans to be

subject to state insurance requirements. As a result, the Connecticut Insurance Department does not have jurisdiction over self-insured plans. Such plans are under the U.S. Department of Labor's jurisdiction.

COMMITTEE ACTION

Labor and Public Employees Committee

Joint Favorable
Yea 8 Nay 2 (03/18/2014)